MassHealth Personal Care Attendant (PCA) Program

OVERTIME APPROVAL REQUEST FORM

MassHealth

THE COMMONWEALTH OF MASSACHUSETTS
Executive Office of Health And Human Services

CONSUMER INFORMATION

Consumer Name	Date of Birth
MassHealth ID Number	PA Number
Consumer ID Number	Consumer Phone Number
Consumer Address	
Surrogate Name (if applicable)	Surrogate Phone (if applicable)

PERSONAL CARE ATTENDANT PROVIDER INFORMATION

PCA Name	PCA Unique Identifier/Provider Number
PCA Address	
PCA Phone Number	

REQUEST OVERTIME APPROVAL TYPE

☐ Consumer Living with PCA (consumer approved for 40-60 hours per week) (go to **SECTION A**)

☐ Continuity of Care Short-Term (go to **SECTION B**)

SECTION A: CONSUMER LIVING WITH PCA

The consumer must be approved for 40-60 hours per week, live with the PCA, and the PCA must be the only PCA working for the consumer. Please provide documentation that you and your PCA live together.

PROOF OF RESIDENCY REQUIRED DOCUMENTS:

Must include a minimum of two for the PCA. Documents must include physical address and not a PO Box.

PCA name and address must be on 2 documents below (select and attach both to this document)

- ☐ Gas/Oil bill - no older than three months
- ☐ Water bill - no older than three months
- ☐ Electric bill - no older than three months
- ☐ Cable TV bill - no older than three months
- ☐ Phone bill - no older than three months
- ☐ Current homeowner's or renter's insurance certificate
- ☐ Current automobile insurance certificate
- ☐ Vehicle registration title
- ☐ Voter registration card
- ☐ Property tax bill or receipt
- ☐ Residential rental contract (apartment lease or other rental of real property or original and signed verification letter from landlord)
- ☐ Driver's license or state-issued identification
- ☐ Change of address confirmation from U.S. Postal Service
- ☐ Other form or documentation that contains information identifying the PCA's name and residence

SECTION B: CONTINUITY OF CARE SHORT-TERM

The consumer must demonstrate that the current PCA must work more than 40 hours per week to avoid a disruption in care while the consumer seeks additional PCAs. Please provide a description of your request below. If additional space is required, please attach a signed and dated document to this form.

Select One: ☐ I am the only consumer my PCA works for.
☐ My PCA works for me and other PCA consumers more than 40 hours per week.

Describe

Total number of hours/week requested for PCA to work

ATTESTATION ORIGINAL SIGNATURES REQUIRED

CONSUMER/SURROGATE

I certify that I have reviewed and confirm that the information contained herein is true and accurate. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein. This documentation will be retained by my PCM Agency in my record and in the event of an audit, the MassHealth agency may at its discretion request any and all medical records of MassHealth Consumers corresponding to, or documenting the services claimed, in accordance with 130 CMR 422.000 and 130 CMR 450.204 and 450.205.

I WILL NOTIFY MY FISCAL INTERMEDIARY IMMEDIATELY IF I HIRE ADDITIONAL PERSONAL CARE ATTENDANTS OR IF MY LIVING CIRCUMSTANCES CHANGE.

Consumer Signature Date / /

Surrogate Signature (if applicable) Date / /

PERSONAL CARE ATTENDANT

I certify that I have reviewed and confirm that the information contained herein is true and accurate. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein. This documentation will be retained by the PCM Agency in the consumer's record and in the event of an audit, the MassHealth agency may at its discretion request any and all medical records of MassHealth consumers corresponding to, or documenting the services claimed, in accordance with 130 CMR 422.000 and 130 CMR 450.204 and 450.205.

PCA Provider Signature Date / /

PERSONAL CARE MANAGEMENT AGENCY

I certify, to the best of my knowledge, that the information on this form is true, accurate, and complete.

PCM Agency Name

PCM Agency Signature Date: / /

PCM Agency, select one of the following: consumer is in: ☐ FFS ☐ SCO ☐ One Care
If SCO or One Care is checked, fill in:
Approved number of hours per week (day/eve plus night) _____ Approval Start Date / / End Date / /

MassHealth Personal Care Attendant Program

INSTRUCTIONS FOR CONSUMER/SURROGATES TO FILL OUT OVERTIME REQUEST FORM

In accordance with the MassHealth PCA regulation at 130 CMR 422.420(A)(5)(b), consumers are required to ensure that each PCA works no more than 40 hours per week unless the consumer is approved for a time limited approval to schedule overtime pursuant to 130 CMR 422.418(C). PCAs are required to adhere to the weekly hour limit or approved overtime hours in accordance with the MassHealth PCA regulations at 130 CMR 422.419(C)(3) and (4) and may be subject to sanctions for violating this provision, including suspension or termination.

INSTRUCTIONS FOR FILLING OUT AND SUBMITTING THIS FORM

You, the consumer or surrogate, if applicable, must fill out this form and make copies of any required documentation. To request assistance in filling out this form, contact your PCM Agency. Submit this form and required documentation to your PCM Agency.

CONSUMER INFORMATION

Fill in your information to include your name, address, phone number, MassHealth ID number, consumer ID number, date of birth and PA number. If you have a surrogate, include your surrogate's name and phone number.

PERSONAL CARE ATTENDANT INFORMATION

Fill in your PCA's information to include name, address, phone number, and PCA Unique Identifier/Provider Number, located on your PCA's Activity Sheet. If you do not know your PCA's Unique Identifier/Provider Number, contact your fiscal intermediary.

REQUEST OVERTIME TYPE

Indicate which overtime request you are seeking. If you are approved to schedule overtime, the number of approved hours will not exceed the amount of your approved prior authorization hours.

Consumer Living with PCA. This request to schedule overtime may apply if you meet all of the following:

1) A consumer has been approved by MassHealth to schedule more than 40 but less than 60 hours per week of personal care services,
2) The consumer lives in the same home as the PCA, and
3) The consumer receives all of his or her care from that one PCA.

If approved, the consumer living with PCA request to schedule overtime will be valid for the consumer's prior authorization period and must be validated every year.

Continuity of Care Short-term. This request to schedule overtime may apply if you meet the following:
The consumer requires his or her individual PCA to work more than 40 hours per week for a short-term basis to avoid a disruption in care while the consumer seeks additional PCA(s) and adjusts the number of hours the PCAs work the consumer.

SECTION A: CONSUMER LIVING WITH PCA REQUEST

Provide a copy of two different required documents from the list for your PCA. All documents must have the same address physical street address (not a PO Box) and the PCA's name must be listed on both documents.

SECTION B: CONTINUITY OF CARE SHORT-TERM REQUEST

Select one of the two reasons for your Continuity of Care request. Explain in detail the reason your PCA must work more than 40 hours per week to avoid a disruption in your care while you seek additional PCAs. Fill in the total number of hours per week you are requesting for your PCA to work. The number of hours cannot exceed the total amount of your approved prior authorization hours. If additional space is required, please attach signed and dated document to the form.

ATTESTATION

CONSUMER/SURROGATE

You and your surrogate, if any, must sign and date the form and must certify that all information contained within the form is true, accurate, and complete.

PERSONAL CARE ATTENDANT

Your PCA must sign and date the form and must certify that all information contained with the form is true, accurate, and complete.

PERSONAL CARE MANAGEMENT AGENCY

The PCM Agency representative must fill in the PCM Agency name, sign and date the form and certify that the information is true, accurate, and complete to the best of the PCM Agency's knowledge. The PCM Agency must select if the consumer is enrolled in Fee for Service (FFS), Senior Care Options (SCO) or One Care. If the consumer is enrolled in SCO or One Care, fill in the approved number of hours per week (day/eve plus night) and SCO or One Care approval start and end date.

ALL DOCUMENTS MUST BE MAINTAINED IN THE CONSUMER'S CASE RECORD.